STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY STREET LAKE STATION, IN46405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the Investigation of Complaint IN00094623. Complaint IN00094623-Substantiated. State residential deficiencies related to the allegation are cited at R0036, R0045, R0090 and R0091. Survey dates: August 23 and 24, 2011 Facility number: 001136 Provider number: 001136 AIM number: N/A Survey team: Kelly Sizemore, RN-TC Regina Sanders, RN Sheila Sizemore, RN Census bed type: Residential: 128 Total: 128 Census payor: Medicaid: 117 Other: 11 Total: 128 Residential sample: 3 These state residential findings are cited in accordance with 410 IAC 16.2.	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on August 29, 2011 by Bev Faulkner, RN			
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to notify a resident's physician and legal guardian related to a resident moving out of the facility in the middle of the night, for 1 of 3 closed records reviewed for physician and legal representative notification in a sample of 3. (Resident B) Findings include: Resident B's closed record was reviewed on 8/24/11 at 9:30 a.m. Resident B's diagnoses included, but were not limited to, bipolar manic disorder, diabetes, and schizoaffective disorder. An undated incident report filled out by the Administrator, indicated "Incident date Sunday July 31st, Monday Aug. 1st, 2011,	R0036	1. What corrective actions will be accomplished for those residents found to have been affected by the defieicnt practice.Based on the descriptions given in the Summary Statement of Deficiencies and no key of identifers given by survey team, facility assumed who residents are:Resident B no longer resides at Lake Park Residential and facility was informed by guardian that resident would not be returning and will be placed in group home.2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents of Lake Park Residential have the potential to be affected by this alledged deficient practice.The Nursing Staff will be inserviced on identifying changes in resident	10/11/2011

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	Incident time midnight or after...Brief Description of Incident: Resident was observed by another resident moving her personal items...into the vehicle...of a former male resident...this was done at approx (approximately) 12 midnight or later..." The first documentation in the nurses' notes was on the following date and times, 8/2/11 at 12:30 a.m., "called daughter re: whereabouts-got voicemail left message per requested by administrator." 8/2/11 at 6:40 a.m., "Daughter called-has not seen mother as of this time..." 8/2/11 at 9:00 a.m., "Resident remains AWOL (absent without leave)..." There was a lack of documentation in the nurses' notes the resident's physician and guardian had been notified in a timely manner that the resident had left the facility. During an interview with the Administrator, on 8/23/11 at 12:00 p.m., she indicated she had notified the resident's guardian on 8/1/11 but was unsure of the time.		behaviors.The Nursing Staff will be inserviced on notifying a residents physician and legal representative in a timely manner when there has been a change in resident behavior and if the resident leaves the building without signing out ot notifying staff.3. What measure will be put into place or what systemic changes the facility will make to ensure that the deficient poractice does not recur.The Director of Nursing will randomly check clinical records to ensure that resident's physician and legal representative where applicable will be notified of a change in residents behavior.4.How the corrective action will be monitored to ensure the deficient practice will not recur.The Director of Nursing will randomly check clinical records and will monitor for compliance.5. By what date the systemic changes will be completed.October 11, 2011	

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	During an interview with Resident B's guardian, on 8/24/11 at 10 a.m., she indicated the Administrator contacted her the next day but was unsure of the time.			

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R0045	(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility			

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	would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address, telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone			

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	number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. 3. Resident C's closed record was reviewed on 8/24/11 at 8:55 a.m. Resident C's diagnoses included, but were not limited to, schizophrenia, hypertension, and emphysema. A physician's order, dated 7/27/11, indicated "ok D/C (discharge) to community (halfway house)" A nurses' note, dated 7/28/11 at 10:00 a.m., indicated "Resident left facility via facility driver to (name of group home) with medication record-chest x-ray." Resident C's record lacked documentation of a Notice of Transfer/Discharge form. During an interview the DoN indicated on 8/24/11 at 9:35 a.m., "I understand this is an issue."	R0045	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?Based on description given by Statement of Deficienies and no resident identifier key given by Survey Team-Resident B left the facility without notifying the facility staff until after leaving and no longer resides at Lake Park Residential.Resident C was voluntarily discharged from the facility and no longer resides at Lake Park Residential.Resident D was voluntarily discharged from facility and notified facility at the time of leaving facility and no longer resides at Lake Park residential2. How the facility will identify other reisdents having the potential to be affected by the same deficient practice and what corrective action will be taken.All resident have the potential to be affected by this alledged deficient practice.All Nursing Staff will be inserviced on the Notice of Discharge/Transfer Form and nursing staff will complete this form upon discharge.3. What measures will be put into place what systenic changes the facility will make to ensure that the deficient practice does not	10/11/2011

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	Based on record review and interview, the facility failed to provide the residents with a Notice of Transfer/Discharge form, which informs the resident in writing the reason and destination of the transfer and the appeal rights for the transfer for 3 of 3 discharged residents in a sample of 3. (Residents #B, #C, #D) Findings include: 1. Resident #D's closed record was reviewed on 08/24/11 at 8:45 a.m. The resident's diagnoses included, but were not limited to, mild mental retardation and depression.		recur.The Director of Nursing and/or designee will initiate all discharges and will ensure that the resident being discharged is given the Notice of Transfer/Discharge Form with every discharge.4.How will the corrective action be monitored to ensure the deficient practice will not recur.The Nursing Staff will notify the Director of Nursing of any anticipated discharges and the Director of Nursing will provide a copy of Notice of Transfer/DIschrage Form to the Adminstrator with very discharge. The Administrator will monitor for compliance thru random checks of discharges.5. By what date the systemic changes wil be completed.October 11, 2011	

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	A Nurses' Note, dated 07/08/11 at 11:30 a.m., indicated the resident was discharged to an adult foster care. There was a lack of documentation to indicate the resident had been given a Notice of Transfer/Discharge form to inform the resident of the reason, destination and appeal rights for the transfer. 2. Resident #B's closed record was reviewed on 08/24/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, schizo-affective disorder and bipolar manic disorder. A physician's order, dated 08/11/11, indicated the resident was discharged to an outside facility. There was a lack of documentation to indicate the resident had been given a Notice of Transfer/Discharge form to inform the resident of the reason, destination and appeal rights for the transfer. During an interview on 08/24/11 at 10:55 a.m. The Director of Nursing indicated she was unsure of what the Notice of Transfer/Discharge form was. She indicated the residents did not get the information for the discharge.			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to report an unusual occurrence within 24 hours of an incident related to a resident leaving a facility, for 1 of 3 resident closed records reviewed for reporting incidents in a sample of 3. (Resident B) Findings include: An undated policy titled, "UNUSUAL OCCURRENCES-POLICY & PROCEDURES," received as current from the Administrator, on 8/24/11 at 8:30 a.m., indicated "All unusual occurrences (covered in the ISDH P & P (policy and procedures) will be reported to the Administrator within two hours of occurrence...On weekends either the Evening Supervisor or RN will be responsible for contacting the Administrator..." There is lack of documentation in the policy regarding when the Administrator should report unusual occurrences to ISDH. Resident B's closed record was reviewed on 8/24/11 at 9:30 a.m. Resident B's diagnoses included, but were not limited	R0090	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice.Based on the description in the Summary Statement of Deficiencies, it can only be assumed who Resident B is, due to identifier key not given by survey team at exit.Resident B no longer resides at Lake Park Residential.2.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.All residents have the potential to be affected by this alledged deficient practice.All staff will be inserviced on reporting unusual occurences to the Administrator within two hours of occurence.3.What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?Unusal occurences will be documented on the 24 hour report form to ensure that all nursing staff are aware of any unusal occurence that has occured .4..How will the corrective actions be monitored to ensure the deficient practice will not recur.The Administrator and/or designee will randomly audit clinical records and 24	10/11/2011

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	to, bipolar manic disorder, diabetes, and schizoaffective disorder. An undated incident report filled out by the Administrator, indicated "Incident date Sunday July 31st, Monday Aug. 1st, 2011, Incident time midnight or after...Brief Description of Incident: Resident was observed by another resident moving her personal items...into the vehicle...of a former male resident...this was done at approx (approximately) 12 midnight or later..." Review of a facsimile transmittal sheet indicated the ISDH (Indiana State Department of Health) was notified on the dates of August 5, 2011 and August 8, 2011. During an interview with the Administrator, on 8/23/11 at 11:55 a.m., she indicated another resident told her the next day when she came into work about Resident B putting her things in a van. During an interview with the Administrator, on 8/23/11 at 12:10 p.m., she indicated she notified ISDH, APS (Adult Protective Services) and the Ombudsman the next day. During a telephone interview with APS on 8/23/11 at 1:20 p.m., they indicated they		hours reports for documentation of occurences. Administrator and/or designee will inform residents at resident council meeting that any incidents or concerns should be reported to the staff and/ or Administrator.5.By what date the systemic changes will be completed. October 11, 2011	

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	were notified by the facility on 8/5/11.			
R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on record review and interview, the facility failed to ensure the policy and procedure was followed for notifying the administrator of an unusual occurrence related to a resident moving out of the facility in the middle of the night, for 1 of 3 closed records reviewed for discharges in a sample of 3. (Resident B) Findings include: Resident B's closed record was reviewed on 8/24/11 at 9:30 a.m. Resident B's diagnoses included, but were not limited to, bipolar manic, diabetes, and schizoaffective disorder. An undated policy titled, "UNUSUAL OCCURRENCES-POLICY & PROCEDURES," received as current	R0091	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.Based on the description in Summary Statement of Deficiencies, it is assumed whom Resident B is due to no identifer key given by survey team upon exit.Resident B no longer resides at Lake Park Residential.2.How will the facility identify other residents having the potential to be affected by the sale deficient practice and what corrective action will be taken.All reisdents in the facility have the potential to be affected by this alledged deficient practice.All staff of Lake Park Residential including registry nursing staff, will be inserviced on the policy regarding residents leaving the building. 3. What measures will be out into place and what systemic changes the facility will make to ensure that the deficient	10/11/2011

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	from the Administrator, on 8/24/11 at 8:30 a.m., indicated "All unusual occurrences (covered in the ISDH P & P (policy and procedures) will be reported to the Administrator within two hours of occurrence..." An undated facility policy titled, "RESIDENTS LEAVING THE BUILDING," received as current from the Administrator on 8/24/11 at 8:15 a.m., indicated "...THE POLICY IS RESIDENTS MAY LEAVE THE BUILDING BUT MUST BE IN THE BUILDING BY 1:00 AM..." An undated incident report filled out by the Administrator indicated "Incident date Sunday July 31st, Monday Aug. 1st, 2011, Incident time midnight or after...Brief Description of Incident: Resident was observed by another resident moving her personal items...into the vehicle...of a former male resident...this was done at approx (approximately) 12 midnight or later..." The resident's record lacked documentation the Administrator was notified of the resident leaving the building with her belongings. During a telephone interview, on 8/24/11 at 11:15 a.m., Security Guard #3,		practice does not recur.Nursing Staff and Security Staff will make rounds hourly and will report if any resident leaves the building after 1:00AM. Staff will report residents observed leaving the building to the Charge Nurse on duty who in return will report incident to Director of Nursing and Administrator and will document incident in clinical records and 24 hour nursing report form.4.How will the corrective action be monitored to ensure the deficient practice will not recur.Director of Nursing will review 24 hours report forms weekly and will randomly check clinical records and report findings to Administrator.Administrator will monitor for compliance.5. By what date the systemic changes will be completed.October 11, 2011	

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LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY STREET LAKE STATION, IN46405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated CNA #2 had told him Resident B had moved her refrigerator and television out and got into a van with her boyfriend. He indicated he immediately checked Resident B's room and Resident B was gone and he immediately reported it to the nurse on duty. During a telephone interview, on 8/24/11 at 11:16 a.m., RN #1 indicated, CNA #2 had informed her the resident was not in the building. During an interview, at 8/23/11 at 12 p.m., the Administrator indicated the nurse did not call her when the incident occurred. She indicated the incident was passed on in shift report but was unsure what time she was notified on 8/1/11. During an interview on 8/24/11 at 10:47 a.m., the DoN (Director of Nursing) indicated the nurse did not follow the policy. She indicated the nurse should have called the Administrator.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/24/2011

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